

**APPLICATION FOR RENEWAL OF GENERAL ANESTHESIA OR PARENTERAL
 SEDATION ADMINISTRATION AND/OR FACILITY PERMIT**

| | | | |
|---|--------------------------------|--|---------------------|
| RENEWAL DEADLINE: APRIL 30, 2004 (POSTMARKED). | | | |
| Renewal Fee: \$450.00 | | Social Security Number: - - | |
| License Number: | | Business Address: | |
| | | Work Phone: () | |
| | | Requested Permit Renewal: <input type="checkbox"/> General Anesthesia Administration <input type="checkbox"/> General Anesthesia Facility <input type="checkbox"/> Parenteral Sedation <input type="checkbox"/> Parenteral Sedation Facility | |
| | | Make Checks Payable to: Maryland State Board of Dental Examiners | Amount Enclosed: \$ |
| PERMITS | | | |
| List expiration dates and permit numbers of each administration and facility permits that you hold: | | | |
| Permit | Permit Number | Expiration | |
| | | | |
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| CONTINUING EDUCATION REQUIREMENTS – PARENTERAL SEDATION ONLY | | | |
| I certify that I have earned the required hours of continuing education (16 hours of continuing education relating to parenteral sedation during the past 12 months and annually for the past five years) as required by the Board. All continuing education documentation must forwarded to the Board along with your renewal application. All verification of completed continuing education is attached. | | | |
| Signature _____ | | Date _____ | |
| PLEASE DARKEN THE APPROPRIATE BOX | | | |
| Yes <input type="checkbox"/> | No <input type="checkbox"/> | 1. Is general anesthesia or parenteral sedation administered by you at this office? | |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Is general anesthesia or parenteral sedation administered in your dental office by a third party other than yourself? | |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Is general anesthesia or parenteral sedation administered by you or a third party at any other secondary office or site owned by you? If yes, please list site(s), address and telephone number. | |
| | | Site | Who Administers |
| | | Address | Telephone |
| | | | |
| | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Please identify by name and license number, if applicable, all personnel including auxiliaries or nurse anesthetists, involved in patient care while general anesthesia or parenteral sedation is administered in the operating area? Please send copies of all current CPR certification or re-certification certificates for all personnel. | |
| | | Name | License Number |
| | | Care Provided | |
| | | | |
| | | | |
| | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Are the expiration dates on all of your emergency medications currently valid? | |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. List below the type of anesthesia/sedation equipment used in your practice. | |
| | | Does the equipment have a fail-safe mechanism? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| | | Site | Name of Machine |
| | | Serial Number | |
| | | | |
| | | | |
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| | | | |
| | | Please identify the type of Pulse Oximeter(s) monitoring equipment used at all sites where general anesthesia or parenteral sedation is administered? | |
| | | Site | Pulse Oximeter Type |
| | | | |
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|--------------------------|--------------------------|--|--|--------------------------|--------------------------|
| | | 7. Is the following information properly recorded on each patient? | | | |
| Yes | No | Patient History | | Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | Anesthesia Record | | <input type="checkbox"/> | <input type="checkbox"/> |
| | | Patient Dental Chart | | | |
| | | Name of Administrator (anesthetist) of anesthetic for each case | | | |
| Yes | No | 8. Has there been a death, substantially disabling incident and/or hospitalization caused by administration of general anesthesia or parenteral sedation for the practice of dentistry since the Board issued the initial permit? If yes, please provide the Board with details of occurrence? | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Effective January 1, 1999, all general anesthesia and parental sedation permit holders must have an EKG machine and be able to interpret the EKG strip. Do you have an EKG machine and can you interpret an EKG strip? | | | |

APPLICANT SIGNATURE AND NOTARY

Signature of Applicant _____ Date: _____

State of Maryland

City/County of _____.

I hereby certify that on this day of _____ of _____, 2004, before a Notary Public for the State of Maryland and the City/County aforesaid, personally appeared _____ and made oath in due form of law under the penalties of perjury that the matters and facts set forth herein are true and correct to the best of his/her information knowledge and belief.

As witnessed my hand and Notarial Seal.

Notary Public

My Commission Expires:

FOR OFFICE USE ONLY

| | | | |
|-----------------------------|------------------|-------------------------------------|------------------|
| Date Renewal Received: | Payment Posted: | Referred to Applications Committee: | Posted in L2000: |
| Referred to Licensing Unit: | License Printed: | License Control Number: | License Mailed: |